MDR Tracking Number: M5-04-2145-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution - General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division (Division) assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on March 15, 2004.

The IRO reviewed CPT Codes 99211, 99212, 99213, 95831, and 97110 that was denied based upon "U".

The Medical Review Division has reviewed the IRO decision and determined that **the requestor prevailed** on the majority of the issues of medical necessity. Therefore, upon receipt of this Order and in accordance with §133.308(r)(9), the Commission hereby orders the respondent and non-prevailing party to **refund the requestor $460.00** for the paid IRO fee. For the purposes of determining compliance with the order, the Commission will add 20 days to the date the order was deemed received as outlined on page one of this order.

The reviewer found that the office visits, CPT Codes 99211, 99212, and 99213, and the therapeutic exercises, CPT Code 97110, **were** found to be medically necessary for dates of service 11/06/03 through 01/19/04. The reviewer found that the muscle testing, CPT Code 95831, for date of service 01/07/04 **was not** found to be medically necessary. The respondent raised no other reasons for denying reimbursement for 99211, 99212, 99213,95831, and 97110.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was not the only issue** to be resolved.

On May 24, 2004, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14-days of the requestor's receipt of the Notice.

- CPT Code 97110 for dates of service 11/06/03 through 11/25/03, 12/03/03, 12/08/03, 12/11/03, and 12/15/03 through 12/18/03 denied as "F". The submitted EOBs show payment; however, the requestor states that no payments have been received for the CPT code. Recent review of disputes involving CPT Code 97110 by the Medical Dispute Resolution section indicate overall deficiencies in the adequacy of the documentation of this Code both with respect to the medical necessity of one-on-one therapy and documentation reflecting that these individual services were provided as billed. Moreover, the disputes indicate confusion regarding what constitutes "one-on-one." Therefore, consistent with the general obligation set forth in Section 413.016 of the Labor Code, the Medical Review Division has reviewed the matters in light all of the Commission requirements for proper documentation. The MRD declines to order payment because the SOAP notes do not clearly delineate exclusive one-on-one treatment nor did the requestor identify the severity of the injury to warrant exclusive one-to-one therapy. Reimbursement is not recommended.

- CPT Code 99212 for date of service 11/07/03 denied as "N". Per Rule 134.202(c) the submitted SOAP note supports services were rendered as billed. Reimbursement in the amount of $47.23 ($37.78 x 125%) is recommended.

- CPT Code 95851 for dates of service 11/24/03 and 12/30/03 neither party submitted EOBs and dates of service 12/15/03 and 12/22/03 denied as "N". Per Rule 134.202(c) submitted SOAP notes support the level of service billed. Per Rule 133.307(e)(2)(B) requestor has submitted convincing evidence of the request for reconsideration. Per the Medicare Fee Schedule reimbursement in the amount of $157.56 ($31.51 x 125% = $39.39 x 4) is recommended.

- CPT Code 99080-73 for date of service 11/26/03. The submitted EOB had no payment exception code and payment was not received by the requestor. According to Rule 129.5 the TWCC-73 is a Commission required report; per Rule 133.106(f)(1) the submitted Work Status Report supports reimbursement in the amount of $15.00.

- CPT Code 97140 for date of service 12/01/03. The submitted EOB had no payment exception code and payment was not received by the requestor. Per the Medicare Fee Schedule and Rule 134.202(c) reimbursement in the amount of $34.05 ($27.24 x 125%).

- CPT Code 99212 for dates of service 12/09/03 and 12/10/03 denied as "F". The requestor did not receive payment for these dates of service. Per the Medicare Fee Schedule and Rule 134.202(c) reimbursement in the amount of $94.46 ($37.78 x 125% = $47.23 x 2) is recommended.

- CPT Code 95999-WP for date of service 12/09/03 denied as "R". On December 9, 2004 the healthcare providers representative withdrew this CPT code from review; therefore, this code is no longer in dispute and will not be reviewed by MDR.

- CPT Code 99212 for dates of service 12/24/03 through 12/30/03. Neither party submitted EOBs. Per Rule 134.202(c) submitted SOAP notes support the level of service billed. Per Rule 133.307(e)(2)(B) requestor has submitted convincing evidence of the request for reconsideration. Per Rule 134.202(b) and (c)(1) reimbursement in the amount of $141.69 ($37.78 x 125% = $47.23 x 3) is recommended.

- CPT Code 97530 (12 units total) for dates of service 12/24/03 through 12/30/03. Neither party submitted EOBs. Per Rule 134.202(c) submitted SOAP notes support the level of service billed. Per Rule 133.307(e)(2)(B) requestor has submitted convincing evidence of the request for reconsideration. Per Rule 134.202(b) and (c)(1) reimbursement in the amount of $437.79 ($30.06 x 125% = $37.54 x 12 = $450.48) is recommended. Requestor billed a lesser amount and reimbursement is recommended at the rate they billed.

On this basis, and pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay the unpaid medical fees as follows:

- in accordance with Medicare program reimbursement methodologies for dates of service on or after August 1, 2003 per Commission Rule 134.202 (c);

- in accordance with TWCC reimbursement methodologies regarding Work Status Reports for dates of service after August 1, 2003 per Commission Rule 134.202 (e)(8);

- plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this order.

This Order is applicable to dates of service 11/06/03, 11/07/03, 11/24/03, 11/25/03, 11/26/03, 12/01/03, and 12/02/03 through 12/30/03 as outlined above in this dispute.

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule 133.307(j)(2)).

This Order is hereby issued this 10th day of December 2004

Marguerite Foster
Medical Dispute Resolution Officer
Medical Review Division

MF/mf

Enclosure: IRO decision

**NOTICE OF INDEPENDENT REVIEW DECISION**

**SECOND AMENDED DECISION**

**Date:** November 24, 2004

**RE:**
**MDR Tracking #:** M5-04-2145-01
**IRO Certificate #:** 5242

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to ___ for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

___ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a reviewer who is a Chiropractor and has an ADL certification. The reviewer has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

**Clinical History**

The claimant is a 28-year-old male who cut the dorsal surface of his left wrist while at work. The laceration was apparently to the left wrist and finger extensors. The claimant was initially seen at ___ of ___ where surgery to repair tendon damage was performed. The claimant was evaluated at ___ on 11/4/03 for continued left wrist pain by ___. ___ recommended the claimant participate in rehabilitation, joint mobilization and myofascial release, which has included 23 dates of service since the initial evaluation. The claimant was also evaluated by ___ who prescribed prescription medication and recommended the claimant to continue with conservative modalities and treatment. The claimant had a MRI of the left wrist on 12/4/03 at ___, which was negative. The claimant was evaluated by ___ who recommended surgery for a lacerated ulnar nerve and extensor tendon. The claimant also had a designated doctor evaluation on 2/10/04 by ___ who determined the claimant was not at maximum medical improvement. The claimant continues to complain of left wrist pain at a 3 out of 10 maximum pain scale.

**Requested Service(s)**

Office Visit codes 99211, 99212, 99213 dates 11/6/03, 11/10/03, 11/24/03, 11/25/03, 12/3/03, 12/8/03, 12/11/03, 12/15/03, 12/16/03, 12/17/03, 12/18/03, 12/22/03, 12/31/03, 1/5/04, 1/7/04, 1/12/04, 1/19/04. Therapeutic Exercises dates 11/26/03, 12/1/03, 12/2/03, 12/9/03, 12/10/03. Muscle Testing – Upper Extremity dates 1/7/04.

**Decision**

I agree with the insurance carrier that muscle testing of the upper extremity is not reasonable and necessary.

I disagree with the insurance carrier and find that office visit codes and therapeutic exercises on the above mention dates of service are reasonable and necessary.

**Rationale/Basis for Decision**

The claimant apparently suffered a laceration of an extensor tendon(s) in the left wrist as a result of the injury which would allow up to 36 physical therapy visits over a 16 week period, which includes therapeutic exercises. Over a 16 week period, the claimant should be instructed with active self-directed home physical therapy. I form this decision by the negative MRI report of the left wrist which was obtained on 12/4/03 and the Official Disability Guidelines 8th Edition. I am somewhat confused why the claimant had muscle testing performed on the upper extremity because ___ SOAP Notes dated 12/18/03 states that the claimants upper extremity manual muscle testing is within normal limits with complete range of motion against gravity with full resistance and I fail to find any clinical evidence by way of diagnostic testing within the provided records which would support muscle testing in the upper extremity.

___ is the treating physician for this claimant and should be allowed to follow-up with his patient 1-2 times monthly to monitor the claimant's progress with home therapy after the 16 week period or 1/23/04. ___ did perform focused examinations on the above mentioned dates, which is documented in the provided medical documentation.